MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82-61

08255

# CERTIFICATE OF DEATH

Reg. Dist. No. 383

**1. PLACE OF DEATH:**

County Washington

City or town Clearspring

(If outside city or town limits, write RURAL NEAR and giva town)

Street address, ~~hospital, or institution:~~ Cumberland St.

Stay in hospital or inst. (yrs., or mos., or days) 10 years

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Clearspring Ward No.

(If outside city or town limits, write RURAL NEAR and giva town)

Street No. Cumberland St.

(If rural giva LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Bebaugh Ankeny

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) August 31, 1858

8. AGE: Years 80 Months 11 Days 11 If less than one day ___ hrs. ___ min.

9. Birthplace Washington County, Md. (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name John T. Ankeny

13. Birthplace Wash. Co. Md.

MOTHER 14. Maiden name Emma M. Newcomer

15. Birthplace Wash. Co. Md.

16. Informant Mrs. H. C. Foster

Address Clearspring Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Aug 14, 1939 (month) (day) (year)

Cemetery or crematory St. Paul's Cemetery

Location Near Clearspring Md.

18. Funeral director Guy Dev-Rawland

Address Clearspring Md.

19. Aug 14 1939 (Date rec'd by registrar) Joseph W. Murray Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Ankeny Aug. 11, 1939, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 —, to — 19 —, and that I last saw him alive on — 19 39.

Immediate cause of death Cerebral Hemorrhage

DURATION 8-11-39

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy no

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury Injured at work?

23. SIGNATURE S. Robert Wells, Deputy Med. Ex. Wash Co. M. D. or other

Address Hagerstown Md. Date signed 8/12/39

Note: Found dead in bed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (165)

08256

# CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 423 Guilford Ave
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 32 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown Ward No. 2
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 423 Guilford Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Maurice A Armsfarger

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Catherine L. Armsfarger
6(c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) Feb. 13 - 1903

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 36 | 5 | 24 | hrs. min. |

9. Birthplace Hagerstown Wash. Co. Md (Town, county, and state)
10. Usual occupation Sub. Mail Carrier
11. Industry or business U. S. Mail
FATHER 12. Name Morris N. Armsfarger
FATHER 13. Birthplace Sabillasville Md
MOTHER 14. Maiden name Ida Miller
MOTHER 15. Birthplace Hagerstown Md
16. Informant Mrs Catherine L. Armsfarger
Address Hagerstown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 9 - 1939 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown Md
18. Funeral director Scott F. Minnich & Son
Address Hagerstown Md
19. 8-9-1939 (Date rec'd by registrar) Chas H Boerner Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7 - 1939, at 11 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19— to — 19—
and that I last saw him alive on — 19—
Immediate cause of death Suffocation by Hanging — DURATION 8-7-39
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy Death by strangulation

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide Date of 8/7/39
Where did injury occur? Hagerstown (City or town) Washington (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Injured at work? No work. co.

23. SIGNATURE J. Robert Wells, Deputy Med. Ex. M. D. or other
Address Hagerstown Md. Date signed 8/8/39

Dr Wells

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MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

08257

Reg. Dist. No. 302

**1. PLACE OF DEATH:**
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: #6 Downsville Pike.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 15 Years.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown, Ward No. 2
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 6 Downsvill Pike.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Andrew S. Baker.

**3. (b) Social Security Number** 214-09-0196

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Goldie Baker
6(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1898

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 40 | 11 | 15 | hrs. min. |

9. Birthplace Chambersburg, Pa. (Town, county, and state)
10. Usual occupation Sheet metal worker.
11. Industry or business

FATHER
12. Name Amos W. Baker.
13. Birthplace Franklyn County, Pa.

MOTHER
14. Maiden name Malinda Winger.
15. Birthplace Franklyn County, Pa.

16. Informant Mrs Goldie Baker.
Address Hagerstown.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 13, 1939. (month) (day) (year)
Cemetery or crematory Norland Cemetery.
Location Chambersburg, Pa.

18. Funeral director Fred W. Kraiss.
Address Hagerstown,

19. 8-12 1939 (Date rec'd by registrar) Chas H Bowers Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10 1939, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1939, to Aug 10 1939, and that I last saw him alive on Aug. 10 1939.

Immediate cause of death Myocardial insufficiency, Subacute infectious bacterial endocarditis

Due to

Due to Streptococcus viridans septicaemia

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Perry T. Prather M. D. [redacted]
Address Hagerstown, Md Date signed Aug. 13. 39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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# STATE OF MARYLAND—CERTIFICATE OF DEATH

08258

**1. PLACE OF DEATH**

County Washington Registration Dist. No. 306

Village or City Blue Ridge Summit No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

**2. FULL NAME** William B. Baldwin

(a) Residence: No. 519 Stockley Gardens Norfolk Va Ward.

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) |
|---|---|---|
| male | white | married |

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Taylor

6. DATE OF BIRTH (month, day, and year) April 16, 1866

| 7. AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 73 | 4 | 14 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Real estate

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation 47 yrs.

12. BIRTHPLACE (city or town) (State or country) Winchester Va

FATHER

13. NAME Dr Robert F. Baldwin

14. BIRTHPLACE (city or town) (State or country) Staunton Va.

MOTHER

15. MAIDEN NAME Caroline Barton

16. BIRTHPLACE (city or town) (State or country) Staunton Va.

17. INFORMANT (Address) Mrs Bessie Taylor Norfolk Va.

18. BURIAL, CREMATION, OR REMOVAL

Place Elmwood Va. Date Sept 2, 1939

19. UNDERTAKER (Address) Walter Y. Grove Waynesboro Pa

20. FILED Aug 31, 1939 Geo W. Ferguson Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** 8 (Month) 30 (Day), 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 8-1-, 1939, to 8-30, 1939

I last saw h alive on , 19 ; death is said to have occurred on the date stated above, at 4:30 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Chronic Myocarditis

Date of onset

Other Contributory Causes of importance:

Name of operation Date of

What test confirmed diagnosis? Objective Subjective Symptoms Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) H. C. Bridgers M. D.

(Address) Blue Ridge Summit Pa

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Arteriosclerosis* | *1915* |
| *Chronic interstitial nephritis* | *1921* |
| *Cerebral hemorrhage* | *July 5, 1927* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* |
| | |
| | |

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**Example II**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Attack of epilepsy* | *1 week ago* |
| *Run over by street car* | *1 week ago* |
| *Peritonitis* | *3 days ago* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gastroenteritis* | *1 year* |
| | |
| | |

**ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN**

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

08259

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Washington Co. Hospital
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Pa. County: Franklin
City or town: Greencastle Ward No. —
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Still Born child (Barnhart)

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | — |

6 (b) Name of husband or wife: —
6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Aug 21, 1939

8. AGE: Years — Months — Days — If less than one day — hrs. — min.

9. Birthplace: Hagerstown, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: D. Howard Barnhart
13. Birthplace: Greencastle, Pa.

MOTHER
14. Maiden name: Ada Schwinger
15. Birthplace: Hagerstown, Md.

18. Informant: D. Howard Barnhart
Address: Greencastle, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: aug. 22-1939 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Greencastle, Pa.

18. Funeral director: C-M. Suter & Sons
Address: Hagerstown, Md.

19. 8-22-39 (Date rec'd by registrar) Chas H. Boevers Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: August 21 1939, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 21 1939, to Aug 21 1939, and that I last saw h— alive on never 19—

| Immediate cause of death | DURATION |
|---|---|
| Birth accident | |
| Premature Separation of placenta | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: C. H. Gilland M. D. or other
Address: Greencastle, Pa. Date signed 8-22-39

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08260

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

**1. PLACE OF DEATH:**

County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 154 W. North Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 40 years.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown Ward No. 5
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 154 W. North Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Edwin M. Beard

**3. (b) Social Security Number**

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarah A. Beard

6(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.): February 17, 1875

**8. AGE:** Years 64 | Months 5 | Days 29 | If less than one day ___ hrs. ___ min.

9. Birthplace: Chewsville-Washington- Md.
(Town, county, and state)

10. Usual occupation: Factory Worker

11. Industry or business: Moller Organ Works

FATHER
12. Name: Isiah L. Beard
13. Birthplace: Washington County, Md.

MOTHER
14. Maiden name: Sarah Mullin
15. Birthplace: Washington County, Md.

16. Informant: Mrs. Sarah A. Beard,
Address: Hagerstown, Md. 154 W. North St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 17, 1939 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss,
Address: Hagerstown, Md.

19. 8-17-39 (Date rec'd by registrar) Chas H. Bowers Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1939. 19 1:30PM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1939, to Aug 15 1939 and that I last saw h[illegible] alive on Aug 15 1939.

Immediate cause of death: Carcinoma of Stomach.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. H. Beachley M. D. or other

Address Hagerstown Md. Date signed Aug 17/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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SEP 6 1939
BUREAU V. S.

08261

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

**1. PLACE OF DEATH:**
County Washington County
City or town Near Mapleville Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Near Mapleville Md.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 8 weeks

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Near Mapleville Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Near Mapleville Md.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Lewis C Beard

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of ~~husband or wife~~ Susan Beard
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mardh 20 1847

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 91 | 5 4 | 28 | hrs. min. |

9. Birthplace Washington County Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden name Susan Beard
15. Birthplace Maryland

16. Informant Roy Beard
Address Near Mapleville Md.

17. Burial
(Burial, ~~cremation, or removal. Which?~~)
Date thereof Aug 22 1939 (month) (day) (year)
Cemetery or crematory Mountain View Cem.
Location Sharpsburg Md.

18. Funeral director Edith V Leaf
Address Williamsport, Md.

19. Aug. 20, 1939 (Date rec'd by registrar) William F. Bast Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 1939, 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10 1939, to Aug 18 1939, and that I last saw h/M alive on Aug 18 1939.

Immediate cause of death Chronic C.V. Renal dis. & Arterio Sclerosis — DURATION 7 yrs.
Due to —
Due to —
Other conditions General Debility — 2 —
(Include pregnancy within 3 months of death)
Major findings:
Of operations None
Of autopsy None

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. B. Draper, M.D. M. D. or other
Address Boonshow, Md. Date signed 8-20-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08262

Reg. Dist. No. 30 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Washington
City or town Clearsville md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: none
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 13 Yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County Wash.
City or town Smithsburg County - Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. not
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR none

**3. (a) FULL NAME** Josiah Evert Bowser

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of ~~husband~~ or wife Pearl Bowser
6(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 10-5-1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 10 | 20 | hrs. min. |

9. Birthplace Smithsburg md (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Farmer
FATHER 12. Name David Bowser
13. Birthplace near Smithsburg md
MOTHER 14. Maiden name Emma Harry
15. Birthplace Deerfield Frederick md
16. Informant Mrs Pearl Bowser
Address Clearsville md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-27-1939 (month) (day) (year)
Cemetery or ~~crematory~~ Smithsburg
Location Smithsburg md
18. Funeral director Geo. B. Hoover
Address Smithsburg md
19. 8-26-1939 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24, 1939, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 4 1939, to Aug 25 1939, and that I last saw him alive on Aug 24 1939.

| Immediate cause of death | DURATION |
|---|---|
| Prostatic Cancer | 1 yr |
| uremia | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations Supra pubic operation for Prostate
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE G. A. Hoffman M. D. or other
Address Smithsburg Md Date signed 8/28/1939

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SEP 8 1939
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

08263

## CERTIFICATE OF DEATH

Reg. Dist. No. 300

**1. PLACE OF DEATH:**

County Washington

City or town Antietam near Sharpsburg.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days) at Home

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Antietam Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Near Sharpsburg
(If rural give LOCATION)

2(a) ~~IF VETERAN, NAME WAR~~

**3. (a) FULL NAME** Harold Roger Boyer

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed or divorced |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife Single

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) January - 24 - 1939

8. AGE: Years — Months 6 Days 25 If less than one day ____ hrs. ____ min.

9. Birthplace Antietam - Wash. Co. Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business at Home

FATHER
12. Name Carl William Boyer
13. Birthplace Antietam Wash. Co. Md.

MOTHER
14. Maiden name Thelma McCoy
15. Birthplace Chestnut Grove Wash. Co. Md.

16. Informant Carl W. Boyer
Address Sharpsburg Md. R.D.

17. Burial Date thereof Aug. 22. 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lutheran Cemetary

Location Sharpsburg Md.

18. Funeral director Wm. D. Bast & Son

Address Boonsboro Md.

19. 8-21-1939 Earl Boyer
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1939, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 1939 to Aug 19 1939; and that I last saw him alive on 8/19/39

| Immediate cause of death | DURATION |
|---|---|
| Hyperpyrexia and Convulsions | 1 day. |
| Due to Acute Colitis | 7 days. |
| Due to | |
| Other conditions Whooping Cough | 5 weeks. |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter L. Shugley M.D.
M. D. or other

Address Sharpsburg Md. Date signed 8/20/39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
SEP 8 1939
U.S.D.A.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (82a)

08264

# CERTIFICATE OF DEATH

Reg. Dist. No. 302

**1. PLACE OF DEATH:**
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 553 W. Church
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 49 years.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown Ward No. 5
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 553 W. Church St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Bell Clingan

3. (b) Social Security Number —

4. Sex Male
5. Color or race white
6. (a) Single, married, widowed, or divorced Widower
6 (b) Name of husband or wife Mary A Clingan
6(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Oct 1 - 1860

8. AGE: Years 78 Months 10 Days 2 If less than one day ___ hrs. ___ min.

9. Birthplace White Post, Va.
(Town, county, and state)
10. Usual occupation Retired R.R. Engineer
11. Industry or business N & W. R. R
FATHER
12. Name Samuel Clingan
13. Birthplace White Post, Va.
MOTHER
14. Maiden name Virginia Board
15. Birthplace White Post Va.
16. Informant Mrs Mame C. Bloom
Address Hagerstown, Md.
17. Burial (Burial, cremation, or removal, Which?) Date thereof Aug. 5-1939 (month) (day) (year)
Cemetery or crematory Rose Hill
Location Hagerstown, Md
18. Funeral director C. M. Suter & Sons
Address Hagerstown Md
19. 8-3 1939 (Date rec'd by registrar) Chas H. Bowers, Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3 1939, at 3 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1918, to Aug 3 1939, and that I last saw him alive on Aug 2 1939.
Immediate cause of death Cerebral hemorrhage
Due to Hypertensive disease
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Walter Lawman, M.D. M. D. or other
Address Hagerstown Date signed 8/3-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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SEP 6 1939
BUREAU V. S.

Dr. Layman.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (72-a) ✓

# CERTIFICATE OF DEATH

08265

Reg. Dist. No. 302

**1. PLACE OF DEATH:**
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Wash. Co. Hospital.
Stay in hospital or inst. (yrs., or mos., or days) 2 days.
Stay in this community (yrs., or mos., or days) 49 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Washington.
City or town Hagerstown Ward No. 3
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Oak.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** William Luther Davis.

**3. (b) Social Security Number** 217-09-9745

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married. |

6 (b) Name of husband or wife Merle
6(c) If alive, give age 53. years

7. Birth date of deceased (mo., day, yr.) Aug 13 - 1889.

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 11 | 21 | ____ hrs. ____ min. |

9. Birthplace Marlowe, Berkley Co. Va.
(Town, county, and state)
10. Usual occupation Carpenter.
11. Industry or business Work for himself.
FATHER 12. Name John Davis.
13. Birthplace Marlowe W. Va.
MOTHER 14. Maiden name Emma Lowery.
15. Birthplace Downsville Md.
16. Informant Mrs Merle Davis.
Address Hagerstown, Md.
17. Bury (Burial, cremation, or removal. Which?) Date thereof Aug-5-1939 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery.
Location Hagerstown Md.
18. Funeral director Andrew M. Coffman
Address Hagerstown Md.
19. 8-5 (Date rec'd by registrar) 19 39 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3 1939, at 5:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 12 1938 to August 3 1939, and that I last saw him alive on August 2 1939.

| Immediate cause of death | DURATION |
|---|---|
| Splenomyelogenous leukemia | 9 mos. |
| Due to | |
| Due to | |
| Other conditions Pulmonary edema | 1 hour |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R B Norment M.D.
M. D. or other
Address Hagerstown Md Date signed 8/3/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Norment

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SEP 6 1939
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82-E)

08266

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

**1. PLACE OF DEATH:**
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 619 Penn Ave.
Stay in hospital or Inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 16 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(If newborn infant, give residence of mother)
State Maryland County Washington
City or town Hagerstown Ward No. 5
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 619 Penn Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Nannie N. Earley

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col'd | Married |

6 (b) Name of husband or wife Chas Earley
6(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) May 18 - 1902

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 37 | 2 | 19 | hrs. min. |

9. Birthplace Hagerstown Md (Town, county, and state)
10. Usual occupation House Work
11. Industry or business at Home

FATHER
12. Name George W. King
13. Birthplace W. Va.

MOTHER
14. Maiden name Agnes Dorsey
15. Birthplace W. Va.

16. Informant Chas Earley
Address 619 Penn Ave

17. Burial Date thereof Aug - 5 - 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rosehill Cemetery
Location Hagerstown Md

18. Funeral director Thos M Caldwell
Address 160 N Jonathan St Hagerstown Md

19. 8-4-39 Chas H Bowers
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 2nd 1939, at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1939, to Aug. 2nd 1939, and that I last saw her alive on August 2nd 1939.

| | DURATION |
|---|---|
| Immediate cause of death Cerebral Thrombosis | 7/31-8/2/39 |
| Due to Influenza (Gastro-intestinal form) | 7/16-7/31/39 |
| Due to | |
| | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank T. Shupp M.D. M. D. or other
Address 10½ N. Potomac St. Hagerstown Md. Date signed 8/3/39

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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SEP 6 1939
BUREAU V. S.

# STATE OF MARYLAND—CERTIFICATE OF DEATH

08267

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

**1. PLACE OF DEATH** (93)

County Washington Registration Dist. No. 302

Village or City Hagerstown RD 4 No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

**2. FULL NAME** REUBEN H. EBY If U. S. Veteran, specify WAR

(a) Residence: No. Hagerstown RD 4 St., Ward.

(Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) |
|---|---|---|
| Male | White | Widower |

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Amanda Reiff

6. DATE OF BIRTH (month, day, and year) July 24 1856

| 7. AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 83 | 0 | 9 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Farmer

10. Date deceased last worked at this occupation (month and year) 1920

11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (city or town) (State or country) Penna

FATHER

13. NAME Jonas Eby

14. BIRTHPLACE (city or town) (State or country) Penna

MOTHER

15. MAIDEN NAME Susana Hershey

16. BIRTHPLACE (city or town) (State or country) Penna

17. INFORMANT Noah R Eby (Address) Hagerstown RD 2

18. BURIAL, CREMATION, OR REMOVAL Place Reiff Date Aug 6, 1939

19. UNDERTAKER D. E. Minnich (Address) Greencastle Pa

20. FILED Aug. 4, 1939 Janet M. Foltz Deputy Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** Aug (Month) 5 (Day), 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 22, 1939, to Aug 2, 1939

Last saw h[illegible] alive on Aug 2, 1939; death is said to have occurred on the date stated above, at 12:20 P.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Ca. Myocarditis | 1921 |
| Other Contributory Causes of Importance: | |
| Hypertrophy of Prostate | 1930 |
| with urinary retention | |

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did Injury occur? (Specify city or town, county and State)

Specify whether injury occurred In INDUSTRY, In HOME, or In PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) [signature] M. D.

(Address) Hagerstown Md

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

# UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Arteriosclerosis* | *1915* |
| *Chronic interstitial nephritis* | *1921* |
| *Cerebral hemorrhage* | *July 5, 1927* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* |
| | |
| | |

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BUREAU V. S.

Example II

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Attack of epilepsy* | *1 week ago* |
| *Run over by street car* | *1 week ago* |
| *Peritonitis* | *3 days ago* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gastroenteritis* | *1 year* |
| | |
| | |

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08268

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Washington
City or town Boonsboro
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or Institution: Main Street
Stay in hospital or inst. (yrs., or mos., or days) at Home
Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Boonsboro Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Main Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Annie Maria Eigenbrode

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

B (b) Name of husband or wife William J. Eigenbrode

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) March 19 1866

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 5 | 7 | ____ hrs. ____ min. |

9. Birthplace Fairfield Penna.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Thomas Eigenbrode
13. Birthplace Woodsboro Md.

MOTHER
14. Maiden name Annie Hankey
15. Birthplace Gettysburg Penna.

16. Informant Mrs. William Donaldson
Address Boonsboro Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 29. 1939 (month) (day) (year)
Cemetery or crematory U. B. Cemetary
Location Thurmont Md.
18. Funeral director W. J. Bast & Son
Address Boonsboro Md.

19 Aug. 28. 1939 (Date rec'd by registrar) William J. Bast Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH August 26 1939, at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1939, to Aug 26 1939, and that I last saw h ER alive on Aug. 26 1939.

Immediate cause of death Carcinoma, Bladder — DURATION ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Dt operations Carcinoma, Urinary Bladder.
Dt autopsy None

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. B. Draper M.D.
M. D. or other
Address Boonsboro. Md Date signed Aug. 28 1939

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SEP 6 1938
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(34) CB

08269

# CERTIFICATE OF DEATH

Reg. Dist. No. 302

**1. PLACE OF DEATH:**

County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Washington Co. Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 hr.

Stay in this community (yrs., or mos., or days): —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Penna County: Washington

City or town: Monongahela Ward No. 3rd
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 906 Lawerence St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: World War ✓

**3. (a) FULL NAME:** John Merle Frost

**3. (b) Social Security Number:**

4. Sex: Male

5. Color or race: W.

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Elizabeth Frost

6(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): Jan 28 1890

**8. AGE:** Years: 49 Months: 7 Days: 21 If less than one day: ___ hrs. ___ min.

9. Birthplace: Vanceville Pa
(Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: "

FATHER
12. Name: John W Frost
13. Birthplace: Brownsville Pa

MOTHER
14. Maiden name: Mary Elizabeth Hoffman
15. Birthplace: Vanceville Pa

16. Informant: John W Frost

Address: 906 Lawerence Monongahela Pa

17. removal (Burial, cremation, or removal. Which?) Date thereof: Aug. 19-1939 (month) (day) (year)

Cemetery or crematory: Memorial Cemetery

Location: Monongahela Penna

18. Funeral director: Beboat & Yohe

Address: Monongahela Penna.

19. 8-19-1939 (Date rec'd by registrar) Chas H Bowers Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 18 1939, at 6 P.M. 37

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19__, to ___ 19__, and that I last saw him alive on ___ 19__.

Immediate cause of death: Luetic meningitis — DURATION: 8-17-39

Due to: Cerebral Edema — 8-18-39

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

Of autopsy: No

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work?

23. SIGNATURE: S. Rohrs & Wells Wash. Co. Med. Ex. Deputy M. D. or other

Address: S. Hagerstown, Md. Date signed: 8/19/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M) (T)

RECEIVED
AUG 23 1939
BUREAU V. S.

08270

# STATE OF MARYLAND
# CERTIFICATE OF DEATH

Registration Dist. No. 302

1 PLACE OF DEATH

County Washington

WITHIN CORPORATE LIMITS OF

Village or City Hagerstown (No. 38 Avalon St.: 1 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Baby Girl Gerkins

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) S.

6 DATE OF BIRTH Aug 30, 1939 (Month) (Day) (Year)

7 AGE ..... yrs. ..... mos. ..... ds. If LESS than 1 day ..... hrs. or ..... min. Stillborn

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed or (employer) None

9 BIRTHPLACE (State or country) Hagerstown Md.

PARENTS

10 NAME OF FATHER Chas. H. Gerkins

11 BIRTHPLACE OF FATHER (State or country) Cumberland

12 MAIDEN NAME OF MOTHER Alice Farrell

13 BIRTHPLACE OF MOTHER (State or Country) Medland Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles H. Gerkins

(Address) Hagerstown, Md.

15 Filed 8/31 1939 Chas H Bowers Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 30, 1939 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 30 1939 to Aug 30, 1939, that I last saw h 1 ~~alive on~~ Stillborn, 192..., and that death occurred on the date stated above, at ..... m.

The CAUSE OF DEATH * was as follows:

Stillborn

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory Secondary

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Beachley M. D.

Aug 30 1939 (Address) Hagerstown Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL On Premises

DATE OF BURIAL 8/31/1939

20 UNDERTAKER Father

ADDRESS Hagerstown Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

# Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former* (*retired 6 yrs*). For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," *etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

**If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.**

SEP 6 1939

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (82-a) Reg. Dist. No. 303

# CERTIFICATE OF DEATH

0827

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

**1. PLACE OF DEATH:**

(a) County Washington

(b) City or town Hancock, R.F.D. N
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

**2. HOME (USUAL RESIDENCE) OF DECEASED:**

(a) State Maryland (b) County Washington

(c) City or town Hancock, Md. R.F.D.
(If outside city or town limits, write RURAL and give town)

(d) Street No.
(If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME James Melvin Gordon

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Ida Gordon

6. (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Mar. 22 1867

8. AGE: Years 72 | Months 4 | Days 15 | If less than one day hr. min.

9. Birthplace Fulton Co. Pa.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER

12. Name John Gordon

13. Birthplace Fulton C. Pa.

MOTHER

14. Maiden Name Margret Barton

15. Birthplace Fulton Co. Pa.

16 (a) Informant Mrs. Reed Johnson

(b) Address Hancock, Md. R.F.D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 8 1939 (month) (day) (year)

(c) Cemetery or crematory Union Cemetery

Location Big Cove Pa.

18 (a) Funeral director Snyder Rowland

(b) Address Hancock, Md.

19 (a) 8-7-39 (Date rec'd by registrar) (b) J. D. Jenkins Registrar

## MEDICAL CERTIFICATION

20. Date of death Aug. 6 1939 at 3:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1938, to 8-6-1939

and that I last saw him alive on 8-6-1939

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerosis | |
| Hypertension | |
| Due to Cerebral Hemorrhage | 8-5-39 |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Underlins the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Herbert R. Rokis M. D. or other

Address Hancock Md Date signed 8-7-39

RECEIVED
SEP 7 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

08272

# CERTIFICATE OF DEATH

Reg. Dist. No. 301

**1. PLACE OF DEATH:**

County Washington

City or town Williamsport, Md, R.F.D# 1

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Williamsport, Route # 1 Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George N. Grey.

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary E.

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22, 1864.

8. AGE: Years 75 Months 5 Days 28 If less than one day hrs. min.

9. Birthplace Hagerstown, Md. (Town, county, and state)

10. Usual occupation Retired Steam Fitter.

11. Industry or business

FATHER 12. Name

13. Birthplace Hagerstown., Md.

MOTHER 14. Maiden name Lydia Ann , Harrison,

15. Birthplace Clearspring, Md.

16. Informant John P.

Address Williamsport, Md.

17. Hagerstown, (Burial, cremation, or removal. Which?) Date thereof Aug 23, 1939. (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery,

Location Hagerstown,

18. Funeral director Fred W. Kraiss.

Address Hagerstown.

19. Aug 22 1939 (Date rec'd by registrar) Mrs E Lee McElroy Registrar

## MEDICAL CERTIFICATION

8/30

20. DATE OF DEATH August 20, 1939, 1939, at P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1 1939, to Aug 20 1939, and that I last saw him alive on Aug. 20 1939.

Immediate cause of death Myocarditis Chronic followed by Embolus (Not certain whether pulmonary or coronary)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION 2 years

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide No. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE I. M. Pennuway M. D. or other

Address Williamsport Md Date signed 8/20/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 4 1939
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

08273

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Washington (WITHIN CORPORATE LIMITS OF)

City or town Hagerstown (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 121 Bethel Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 57 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State Maryland County Washington (WITHIN CORPORATE LIMITS OF)

City or town Hagerstown Ward No. 5 (If outside city or town limits, write RURAL NEAR and give town)

Street No. 121 Bethel Street (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Edward S. Gross

**3. (b) Social Security Number** 220-10-3498

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Elenor Gross

6(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) May 31, 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 2 | 26 | ____ hrs. ____ min. |

9. Birthplace Hagerstown- Washington Md. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Last Employment W P A

FATHER 12. Name Edward T. Gross

13. Birthplace Hagerstown, Md.

MOTHER 14. Maiden name Anna Stinebaugh

15. Birthplace Hagerstown, Md.

18. Informant Mrs. Elenor Gross

Address 121 Bethel St.- Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 29, 1939 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

16. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. 8-29-39 (Date rec'd by registrar) Chas. H. Bowers Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH August 26, 1939, at 9:45P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30 1939 to Aug 26 1939

and that I last saw him alive on Aug 26 1939

Immediate cause of death Tuberculosis Pulmonary — DURATION 4 mo

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy Not any

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. M. Wallace Brown M. D. or other

Address Hagerstown Md Date signed 8-29-39

RECEIVED
SEP 6 1909
BUREAU V. S.

# STATE OF MARYLAND—CERTIFICATE OF DEATH

08274

82-(a)

**1. PLACE OF DEATH**

County Washington Registration Dist. No. 307

Village or City Rohrersville No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

**2. FULL NAME** Almira M. Haynes If U. S. Veteran, specify WAR

(a) Residence: No. Rohrersville Md. St., Ward.

(Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) |
|---|---|---|
| Female | White | Widowed |

5e. If married, widowed, or divorced HUSBAND of (or) WIFE of Millard Haynes

6. DATE OF BIRTH (month, dey, and year) June 27 1860

| 7. AGE | Years | Months | Oeys | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 79 | 1 | 8 | |

OCCUPATION

8. Trede, profession, or perticuler kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work wes done, es SILK MILL, SAW MILL, BANK, etc. Own Home

10. Dete deceesed lest worked et this occupation (month end year) Aug. 1939

11. Total time (yeers) spent in this occupetion Life

12. BIRTHPLACE (city or town) Rohrersville (State or country) Wash. Co. Md.

FATHER

13. NAME Daniel Hupp

14. BIRTHPLACE (city or town) Rohrersville (State or country) Wash. Co. Md.

MOTHER

15. MAIDEN NAME Mary Thomas

16. BIRTHPLACE (city or town) Rohrersville (State or country) Wash. Co. Md.

17. INFORMANT Mrs. Ira Rice (Address) Rohrersville Md.

18. BURIAL, CREMATION, OR REMOVAL Place Rohrersville Md. Date Aug. 8, 1939

19. UNDERTAKER Wm. T. Bart & Son (Address) Boonsboro Md

20. FILED Aug. 8, 1939 Miss Katherine Dorsenbach Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** Aug. (Month) 5 (Oay), 1939 (Yeer)

22. I HEREBY CERTIFY, Thet I attended deceased from July 23, 1939, to Aug 5, 1939.

Hast saw h-m- alive on July 15, 1939; deeth is said to heve occurred on the date steted ebove, at 8:30 P m.

The **PRINCIPAL CAUSE OF DEATH** and releted causes of importance were es follows:

| | Date of onset |
|---|---|
| Arteria Sclerosis | 7-28-35 |
| Cerebral Hemorrhage | 7-12-39. |

Other Contributory Causes of importence:

Neme of operation Date of

What test confirmed diegnosis? Was there en autopsy?

23. If deeth wes due to externel ceuses (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did Injury occur? (Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Menner of Injury

Neture of Injury

24. Wes diseese or injury in any wey releted to occupation of deceesed?

If so, specify

(Signed) J. Frederick Baker M. D.

(Address) Boonsboro Md.

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

# UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

| Example I | | Example II | |
|---|---|---|---|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
| *Arteriosclerosis* | *1915* | *Attack of epilepsy* | *1 week ago* |
| *Chronic interstitial nephritis* | *1921* | *Run over by street car* | *1 week ago* |
| *Cerebral hemorrhage* | *July 5, 1927* | *Peritonitis* | *3 days ago* |
| | | | |
| | | | |
| Other contributory causes of importance: | | Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* | *Gastroenteritis* | *1 year* |
| | | | |
| | | | |

RECEIVED SEP 8 1933 BUREAU U. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

08275

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

82-(2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 307

**1. PLACE OF DEATH:**

County Washington county

City or town Knoxville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Weaverton, Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

**3. (a) FULL NAME** Annie Catherine Himes

**3. (b) Social Security Number**

4. Sex: Female

5. Color or race: white

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Joseph Elmer Himes

Oct 31st 1891 6(c) If alive, give age 47— years

7. Birth date of deceased (mo., day, yr.) Nov 22nd 1888

**8. AGE:** Years 50 Months 8 Days 28 If less than one day ____ hrs. ____ min.

9. Birthplace Augusta, Washington County
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER
12. Name John Wesley Phillips
13. Birthplace Virginia

MOTHER
14. Maiden name Margaret Ellen Hoffmaster
15. Birthplace Brownsville, Washington County

16. Informant J. E. Himes

Address Knoxville Md

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Aug 23rd 1939
(month) (day) (year)

Cemetery or ~~crematory~~ Brownsville Church of Brethren

Location Brownsville, Md.

18. Funeral director J. L. Eackles

Address Bolivar, W. Virginia

Aug 21st 1939 Cornelius H. Castle
(Date rec'd by registrar) Deputy — Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 20th 1939, at 2:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 17 1939, to Aug 20 1939 and that I last saw her alive on Aug 19 1939

Immediate cause of death Cerebral Hemorrhage

DURATION Aug 18 39

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William Shaeffer M. D. or other

Address Brunswick R Date signed Aug 21 39

MARGIN RESERVED FOR BINDING

ASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physic ns: please write the causes of death clearly and legibly.

(M)

(T)

FEV
VS A15

RECEIVED
SEP 6 1939
BUREAU V. S.

08276

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

**1. PLACE OF DEATH:**

County Washington

City or town Hagerstown (WITHIN CORPORATE LIMITS OF)

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Washington Co. Hospital

Stay in hospital or inst. (yrs., or mos., or days) 7 days

Stay in this community (yrs., or mos., or days) 40 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown (WITHIN CORPORATE LIMITS OF) Ward No. 4

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 442 N Mulberry St. L

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Annie E. Hines

**3. (b) Social Security Number** None

4. Sex: female

5. Color or race: white

6. (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Oliver S. Hines

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) March 31 - 1862

**8. AGE:** Years 77 Months 4 Days 5 If less than one day ____ hrs. ____ min.

9. Birthplace Rohrersville Washington Md (Town, county, and state)

10. Usual occupation House wife

11. Industry or business Self

FATHER
12. Name Daniel B Grimm
13. Birthplace Rohrersville Md.

MOTHER
14. Maiden name Ann Stoppa
15. Birthplace Sharpsburg Md.

16. Informant Mrs. Carrie Vance

Address Hagerstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 8-1939 (month) (day) (year)

Cemetery or crematory Rest Haven

Location Hagerstown Md

18. Funeral director Scott F. Minnich Son

Address Hagerstown Md

19. 8-8-1939 (Date rec'd by registrar) Chas A Bowers Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6 1939, at 3.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29, 1939, to August 6, 1939, and that I last saw her alive on August 6, 1939.

Immediate cause of death cerebral hemorrhage

Due to Arteriosclerosis

Due to

Other conditions Negative

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy As per above

DURATION: Don't know.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide x Date of x

Where did injury occur? x (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) x

Means of injury x Injured at work? x

23. SIGNATURE W. R. Bender M.D. (M. D. or other)

Address 34 W. Franklin St. Date signed 8/7/39

Dr Bender

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

08277

Reg. Dist. No. 3/1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Washington

City or town: Near Downsville Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 3 yrs 8 months

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Near Downsville Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Near Downsville Md.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Emma F Houser

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

B (b) Name of ~~husband~~ or wife: Charles B Houser

B(c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): March 25 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 4 | 22 | ____ hrs. ____ min. |

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Joseph Wise

13. Birthplace: Middletown Md.

MOTHER — 14. Maiden name: Susan Gross

15. Birthplace: Maryland

16. Informant: Mrs. Howard Betts

Address: Downsville Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 19 1939 (month) (day) (year)

Cemetery or crematory: Greenlawn Cemetery

Location: Williamsport, Md.

18. Funeral director: Edith V Leaf

Address: Williamsport, Md.

19. Aug 18 1939 (Date rec'd by registrar) J. S. Rowe Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 16 1939, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1936, to Aug 16 1939, and that I last saw h~~im~~ alive on Aug 16 1939

| Immediate cause of death | DURATION |
|---|---|
| Bilateral Hemiplegia. | |
| Cerebral Hemorrhage. | 3 Yrs. |
| Due to | |
| Due to Arteriosclerosis. | 5 Yrs |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Williamsport Md. Date signed: 8/10/39

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3)

08278

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

**1. PLACE OF DEATH:**
County Wash. Clear Spring
City or town Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Big Spring Rd.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md. County Wash.
City or town Big Spring Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. R.F.D.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Unnamed Johnson

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M. | W. | S. |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25, 1939.

8. AGE: Years Stillborn | Months | Days | If less than one day ___hrs. ___min.

9. Birthplace Clear Spring Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Thos. L. Johnson
13. Birthplace Millstone Md.

MOTHER 14. Maiden name Evelyn Mullin
15. Birthplace Clear Spring Md.

16. Informant Thos. L. Johnson
Address Big Spring Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 25 1939 (month) (day) (year)

Cemetery or crematory

Location at Home

18. Funeral director Thos. L. Johnson (Father)
Address Clear Spring Md.

19. Aug 25 1939 (Date rec'd by registrar) Jas. H. W. Murray Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1939, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 25 1939, to Aug 25 1939, and that I last saw h alive on Stillborn 19

Immediate cause of death Heavy lifting - Carrying milk cans — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE David R. Brewer M.D.
M. D. or other
Address Clear Spring Date signed 8/27/39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

08279

Reg. Dist. No. 302

**1. PLACE OF DEATH:**

County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Washington County Hospital

Stay in hospital or inst. (yrs., or mos., or days): 4 days in hospital

Stay in this community (yrs., or mos., or days): 2 months

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown Ward No. 3
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 18 N. Potomac St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

230- 01- 8723.

**3. (a) FULL NAME:** George E. Karikakis.

**3. (b) Social Security Number:** 230- 01- 8723.

| 4. Sex | 5. Color or race | 6.(a) Single, ~~married, widowed, or divorced~~ |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 21, 1891.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | 2 | 27 | ____ hrs. ____ min. |

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Resturant work.

11. Industry or business: Cook

FATHER
12. Name: Unknown
13. Birthplace: Greece

MOTHER
14. Maiden name: Unknown
15. Birthplace: Greece

16. Informant: William Grimes

Address: Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/22/39 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location

18. Funeral director: Fred W. Kraiss.

Address: Hagerstown,

19. 8-22-39 (Date rec'd by registrar) Chas. H. Bowers Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 18, 1939, at 9:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15, 1939, to Aug. 18, 1939, and that I last saw h[illegible] alive on Aug. 18, 1939.

| | DURATION |
|---|---|
| Immediate cause of death: Chronic Pulmonary Tuberculosis. | 1 yr. |
| Due to Cachexia | 1 month |
| Due to Emphysema. | (?) time |
| | |
| Other conditions Passive Congestion of Liver. | 1 month |

(Include pregnancy within 3 months of death)

Major findings:
Of operations: no
Of autopsy: no

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: X Date of: X

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. Howard Geyer M. D. or other

Address: Hagerstown, Md. Date signed: Aug. 19, 1939

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

53-C

08280

Reg. Dist. No. 302

**1. PLACE OF DEATH:**
County Washington
City or town Rural near Hagerstown, Md. (If outside city or town limits, write RURAL NEAR and give town) R F D 4
Street address, hospital, or institution: Marsh Pike
Stay in hospital or insf. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 20 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)
State Maryland County Washington
City or town Rural near Hagerstown Ward No. — (If outside city or town limits, write RURAL NEAR and give town) R F D 4
Street No. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Clyde N. Koons
3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mollie Koons
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): July 23, 1883
8. AGE: Years 56 Months 0 Days 10 If less than one day hrs. min.
9. Birthplace: Franklin County, Pa. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: George A. Koons
13. Birthplace: Franklin County, Pa.
MOTHER 14. Maiden name: Elizabeth Newman
15. Birthplace: Franklin County, Pa.
16. Informant: Mrs. Mollie Koons
Address: Hagerstown, Md. R. F. D. 4
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 5, 1939 (month) (day) (year)
Cemetery or crematory: Green Hill Cemetery
Location: Greencastle, Pa.
18. Funeral director: Fred W. Kraiss,
Address: Hagerstown, Md.
19. 8-4-1939 (Date rec'd by registrar) Chas H Bowers Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 1939- 19 , at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-1-39 19 to 8-2- 1939, and that I last saw ~~him~~ alive on 8-1-39 19
Immediate cause of death (Glioma)
Due to Tumor of Brain; malignant. Duration six months.
left frontal lobe C.W.G.R.
Due to
Patient was operated upon at the University of Maryland Hospital, Baltimore
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION 4/1/39

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dr. E W Dettop M. D. or ~~other~~
Address Hagerstown Md Date signed 4/7/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (942)

# CERTIFICATE OF DEATH

08281

Reg. Dist. No. 302

**1. PLACE OF DEATH:**
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: In Cab mounts to hosp. Washington County Hospital.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 15 Years.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Washington.
City or town: Hagerstown Ward No. 5
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 624 W. Franklyn St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: 705- 10- 4933.

**3. (a) FULL NAME:** William C. Kyner.

**3. (b) Social Security Number:** 705- 10- 4933.

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Divorced.
6 (b) Name of husband or wife: Bertha Johns
6 (c) If alive, give age: Divorced years
7. Birth date of deceased (mo., day, yr.): Dec 9, 1875.
8. AGE: Years 64 Months 8 Days 11 If less than one day ___ hrs. ___ min.
9. Birthplace: Franklyn County Pennsylvania. (Town, county, and state)
10. Usual occupation: Retired Rail Road
11. Industry or business: Engenier. Pattern maker
FATHER 12. Name: Jacob Kyner.
13. Birthplace: Frankltn County , Pa.
MOTHER 14. Maiden name: Mary E. Kassnitz.
15. Birthplace: Franklyn County, Pa.
16. Informant: Mrs Anna Kieffer.
Address: Littlestown. Pa.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 23, 1939 (month) (day) (year)
Cemetery or crematory: Cedar Grove.
Location: Chambersburg, Pa.
18. Funeral director: Fred W. Kraiss.
Address: Hagerstown,
19. 8-23-39 (Date rec'd by registrar) Chas H. Bowers Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: August 19 1939, at 9:25 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 —, to — 19 —, and that I last saw him alive on — 19 —.
Immediate cause of death: Coronary thrombosis — DURATION: 8-19-39
Due to: Chr. pyelitis — 1936
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations: none
Of autopsy: None

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?
23. SIGNATURE: S. Rahn & Wells Deputy Wash. Co. Med. Ex. M. D. or
Address: Hagerstown, Md. Date signed: 8/20/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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SEP 6 1939
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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (43)

## CERTIFICATE OF DEATH

08282

Reg. Dist. No. 302

**1. PLACE OF DEATH:**
County Washington (WITHIN CORPORATE LIMITS)
City or town Hagerstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 356½ South Cannon
Stay in hospital or inst. (yrs., or mos., or days) None
Stay in this community (yrs., or mos., or days) 48 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland (WITHIN CORPORATE LIMITS) County Washington
City or town Hagerstown Md. Ward No. 3
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 356½ S. Cannon
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR None

**3. (a) FULL NAME** Atha L. Lapole

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Vernon E. Lapole
6(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Feb 5 - 1891

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | 6 | 15 | ____ hrs. ____ min. |

9. Birthplace Hagerstown Washington Md.
(Town, county, and state)
10. Usual occupation Home maker
11. Industry or business Own Home
FATHER 12. Name William H. Boward.
13. Birthplace Hagerstown Md.
MOTHER 14. Maiden name Edith Garlock
15. Birthplace Hagerstown Md.
16. Informant Mrs. Zella Anthony
Address Hagerstown Md
17. Burial Date thereof aug 22 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown Md.
18. Funeral director Scott F. Minnich & Son
Address Hagerstown Md.
19. 8/24/39 Chas. H. Bowers
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH aug 20 1939, at 3A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17, 1939, to Aug 20 1939, and that I last saw h[illegible] alive on Aug 18 1939

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma - Uterus (Cervix) | 2 yrs |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE Wilbur J. Hershman M. D. or Other
Address Hagerstown Md Date signed 8/24/39

Hirshman

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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Dr. Lusby

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-8)

## CERTIFICATE OF DEATH

08283

Reg. Dist. No. 302

**1. PLACE OF DEATH:**
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 343 S. Cannon Ave
Stay in hospital or inst. (yrs., or mos., or days) at Home
Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown Md. Ward No. 3
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 343 S. Cannon Ave
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Andrew Hershey Marr

**3. (b) Social Security Number**

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mrs. Emma Marr
6(c) If alive, give age: 84 years
7. Birth date of deceased (mo., day, yr.): July 21 1856
8. AGE: Years 83 Months 1 Days 1 If less than one day ____ hrs. ____ min.
9. Birthplace: Hagerstown Wash. Co. Md. (Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business: Flour & Feed Store
FATHER 12. Name: Andrew Marr
FATHER 13. Birthplace: Maplelle Wash. Co. Md.
MOTHER 14. Maiden name: Elizabeth Bomberger
MOTHER 15. Birthplace: Maplelle Wash Co. Md
16. Informant: Mrs. Emma Marr
Address: 343 S. Cannon Ave. Hagerstown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 24. 1939 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.
18. Funeral director: W. T. Best & Son
Address: Boonsboro Md.
19. 8-23- 1939 (Date rec'd by registrar) Chas. H. Bowers Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 8/22 1939, at 11:10 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/15/39 19__ to 8/22 1939, and that I last saw him alive on 8/21 1939.

Immediate cause of death: Arteriosclerotic cardiovascular disease — DURATION: Uncertain
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy No

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE F. F. Lusby M. D. or other
Address Hagerstown Md. Date signed 8/23/39

RECEIVED
SEP 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-E)

08284

# CERTIFICATE OF DEATH

Reg. Dist. No. 302

**1. PLACE OF DEATH:**

County Washington

City or ~~town~~ Hagerstown

(If outside city or town limits, write RURAL NEAR and give town)

Street ~~address~~, hospital, or institution: Washington Co. Hospital

Stay in hospital or inst. (yrs., or mos., or days) 4 days.

Stay in this community (yrs., or mos., or days) [illegible]

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Washington

City or ~~town~~ near Hagerstown Route #3 ~~Ward No.~~

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Mt Aetna Road,

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Annie M. Marshall

**3. (b) Social Security Number**

4. Sex: Female

5. Color or race: white

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or ~~wife~~ Henry C. Marshall

6(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Dec 13 - 1872

**8. AGE:** Years 66 | Months 8 | Days 17 | If less than one day ____ hrs. ____ min.

9. Birthplace Keedysville, Wash. Co. Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business [illegible]

FATHER

12. Name Josephus Hines

13. Birthplace Keedysville, Md.

MOTHER

14. Maiden name Susan Marshall

15. Birthplace Keedysville, Md.

16. Informant Miss Mary Marshall

Address Hagerstown, Md Route 3

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 2 - 1939 (month) (day) (year)

Cemetery or ~~crematory~~ Rest Haven

Location Hagerstown, Md.

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Md.

19. 9 - 2 - 1939 (Date rec'd by registrar) Chas H Bowers Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30th 1939, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 2nd 1939, to Aug 30th 1939 and that I last saw her alive on Aug 30th 1939.

Immediate cause of death: Hypostatic & Neptunitic Heart disease. Hypertension

Due to Anemia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: ? ? ? 1 WK

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Hagerstown Md Date signed 8/31/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A16

RECEIVED
SEP 25 1939
BUREAU V. S

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08285

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Washington County
City or town: Greencastle Pike
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Near Williamsport, Md
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Near Williamsport, Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.:
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Anna Mary Mowen

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife: Melker E Mowen
6(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Feb 26 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 5 | 15 | hrs. min. |

9. Birthplace: Franklin County Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Michel E Neff
13. Birthplace: Franklin Co Pa

MOTHER
14. Maiden name: Elizabeth Butler
15. Birthplace: Franklin Co Pa.

16. Informant: Mrs. Charles Foust (daughter
Address: Chambersburg Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 13 1939 (month) (day) (year)
Cemetery or crematory: Broadfording Cemetery
Location: Near Huyettes Cross Pikes Md.

18. Funeral director: Edith V Leaf
Address: Williamsport, Md.

19. Aug 13 1939 (Date rec'd by registrar) Mrs Edee McElroy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10 1939, at 4:20 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 1939, to Aug 10 1939, and that I last saw h- w- alive on Aug 10 1939

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Tuberculosis, | Unknown |
| Tuberculous Enteritis | Unknown |
| Due to Bacillus Tuberculosis | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations: none
Of autopsy: none

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Amos Robert Shue M.D.
M. D. or other
Address: Clearspring Md Date signed: 8/11/39

RECEIVED
SEP 4 1939
BUREAU V. S.

08286

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (66) (B)

## CERTIFICATE OF DEATH

Reg. Dist. No. 301

**1. PLACE OF DEATH:**

County Washington

City or town Williamsport
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 4 mo.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Penn. County Franklin

City or town Mercersburg. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

**3. (a) FULL NAME** Mary Grier Nevin

**3. (b) Social Security Number**

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

B (b) Name of husband or wife: Bruce Nevin

6(c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.): June 28, 1867

**8. AGE:** Years 72 | Months 1 | Days 6 | If less than one day ___ hrs. ___ min.

9. Birthplace: Sylvan - Franklin Co. Pa
(Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business

FATHER
12. Name: Josiah M. Grier
13. Birthplace: Greenvillage Pa

MOTHER
14. Maiden name: Martha E. Cook
15. Birthplace: Sylvan Pa.

16. Informant: Mrs. J. B. Heffner
Address: Williamsport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 5, 1939 (month) (day) (year)

Cemetery or crematory: Fairview

Location: Mercersburg, Pa.

18. Funeral director: Snyder-Rowland

Address: Clearspring, Md.

19. Aug 4 1939 (Date rec'd by registrar) Mrs Edee McElroy Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3, 1939, at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 3 1939, to Aug 3 1939, and that I last saw her alive on Aug 3 1939.

Immediate cause of death: Acute Cardiac Dilation — DURATION 30 min

Due to: Cardiac Hypertrophy — 1 year

Due to: Toxic Thyroid and Chronic Nephritis — 1 year / 1 year

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: J. M. Pennemann M. D. or other
Address: Williamsport, Md. Date signed Aug 4-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 4 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

08287

93-C

Reg. Dist. No. 302

**1. PLACE OF DEATH:**

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 616 W. Franklin St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 61 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown Ward No. 5

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 616 W Franklin St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** William Shawman Porter

**3. (b) Social Security Number** none

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anne

6(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Oct 12 - 1866

8. AGE: Years 72 Months 10 Days 14 If less than one day ___ hrs. ___ min.

9. Birthplace Sharpsburg Wash Co. Md. (Town, county, and state)

10. Usual occupation Postal Employee.

11. Industry or business Mail Carrier.

FATHER

12. Name Charles W. Porter

13. Birthplace Sharpsburg Md.

MOTHER

14. Maiden name Mary Stiffler.

15. Birthplace St James Md.

16. Informant Mrs Anne Porter

Address Hagerstown. Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Aug 28-1939 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown. Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown. Md.

19. 8-27 1939 (Date rec'd by registrar) Chas H Bowers Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1939, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 23 1939 to Aug. 26 1939, and that I last saw him alive on Aug 26 1939.

Immediate cause of death Chronic Myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A Prather M. D. or other

Address Hagerstown, Md Date signed Aug. 26. 39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Prather Dr Hoffman.

RECEIVED
SEP 6 1909
BUREAU V. S.

08288

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164)

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

**1. PLACE OF DEATH:**

County Washington

City or town Hagerstown (Within corporate limits of) (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Wash. Co Hospital

Stay in hospital or inst. (yrs., or mos., or days) 2 weeks.

Stay in this community (yrs., or mos., or days) 30 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown (Within corporate limits of) Ward No. 2 (If outside city or town limits, write RURAL NEAR and give town)

Street No. 745 W. Wash. St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Earl McClelland Renner

**3. (b) Social Security Number** 214-09-0212

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Helen.

6 (c) If alive, give age 24. years

7. Birth date of deceased (mo., day, yr.) Sept 14 - 1909

**8. AGE:** Years 29 Months 11 Days 2. If less than one day ___ hrs. ___ min.

9. Birthplace Hagerstown, Wash Co. Md. (Town, county, and state)

10. Usual occupation Clerk.

11. Industry or business Peoples Drug Store.

FATHER 12. Name George Renner

13. Birthplace Hagerstown Md

MOTHER 14. Maiden name Mary Ruck.

15. Birthplace Hagerstown Md.

16. Informant Mrs Helen Renner.

Address Hagerstown. Md.

17. Bury (Burial, cremation, or removal. Which?) Date thereof Aug 19-1939 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director Andrew R. Coffman

Address Hagerstown, Md.

19. 8-19- 1939 (Date rec'd by registrar) Chas H Bowers Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1939, at 9 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2 1939, to August 16 1939, and that I last saw him alive on August 16, 1939.

Immediate cause of death: Illuminating gas poisoning

Due to

Due to

Other conditions: Broncho-pneumonia

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 2 wks. / 2 days

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of Aug 2, 1939

Where did injury occur? Hagerstown (City or town), Washington (County), Md. (State)

Injured at home, farm, industry, public place (where?) at home.

Means of injury: gas stove Injured at work? no

23. SIGNATURE S. Robert Wells Wash. Co. Med. Ex. M. D. ~~or other~~

Address Hagerstown, Md Date signed 8/17/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Normant.

RECEIVED
SEP 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 302

# CERTIFICATE OF DEATH

08289

**1. PLACE OF DEATH:**

(a) County Washington

(b) City or town Hagerstown (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Washington County Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

**2. HOME (USUAL RESIDENCE) OF DECEASED:**

(a) State Maryland (b) County Washington

(c) City or town Hancock, Md. Rural (If outside city or town limits, write RURAL and give town)

(d) Street No. Route 40 (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Joseph Russell

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mary E. Russell

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1853

8. AGE: Years 85 Months 9 Days 8 If less than one day ____ hr. ____ min.

9. Birthplace Danville, Virginia (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER

12. Name ---------- Russell

13. Birthplace Unknown

MOTHER

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Henry A. Russell

(b) Address Hancock, Md. R F D

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 11, 1939 (month) (day) (year)

(c) Cemetery or crematory

Location Berkley Springs, W. Va.

18 (a) Funeral director Snyder-Rowland Funeral Home

(b) Address Hancock, Md.

19 (a) 8-10-1939 (Date rec'd by registrar) (b) Chas. H. Bowers Registrar

**MEDICAL CERTIFICATION**

20. Date of death August 8, 1939 at 8:00P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1939, to Aug 7 1939, and that I last saw him alive on Aug 7 1939.

Immediate cause of death Toxaemia

Due to Skin Cancer of face

Due to

Other conditions Advanced Senility

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

Duration

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature F. H. Leutler MD. M. D. or other

Address 134 N. Potomac Hagerstown, Md.

Date signed 8-10-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 6 1939
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

# CERTIFICATE OF DEATH

08290

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Washington

City or town Hagerstown (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: 715 S. Potomac

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 94 years.

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State Md. Maryland County Washington

City or town Hagerstown Ward No. 2nd (If outside city or town limits, write RURAL NEAR and give town)

Street No. 715 S. Potomac St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Susan Ann Santman

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Benjamin F. Santman

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb. 11-1845

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 94 | 5 | 21 | ____ hrs. ____ min. |

9. Birthplace Winchester - Virginia (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business —

FATHER 12. Name Jacob Loop

FATHER 13. Birthplace Unknown

MOTHER 14. Maiden name Katherine Seibert

MOTHER 15. Birthplace Unknown

16. Informant Mrs. Clayton Poffenberger

Address Kendlesville - Ind

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-4-1939 (month) (day) (year)

Cemetery or crematory Mt. View

Location Sharpsburg - Md

18. Funeral director R. E. Grunhaw

Address Kendlesville Ind

19. 8/7/39 (Date rec'd by registrar) Chas. H. Boward Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 1939, at 12:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1939 to Aug. 2 1939, and that I last saw h[illegible] alive on July 20. 1939.

| | DURATION |
|---|---|
| Immediate cause of death Chronic Endo-Carditis | 2 |
| " Nephritis | |
| Due to (a) | |
| Due to (b) | |
| Other conditions — | |

(Include pregnancy within 3 months of death)

Major findings: ✓

Of operations

Of autopsy ✓

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE V. H. Miller M. D. or other

DR. VICTOR D. MILLER,
121 W. WASHINGTON ST.,
HAGERSTOWN, MD.

Address Date signed

RECEIVED
SEP 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

(52)

0829

# CERTIFICATE OF DEATH

Reg. Dist. No. 302

**1. PLACE OF DEATH:**
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 607 S. Potomac St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 9 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown Ward No. 2
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 607 S. Potomac St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR Spanish american

**3. (a) FULL NAME** Albert J. Shrader

**3. (b) Social Security Number** none

4. Sex male
5. Color or race white
6. (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife —
6(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) apr. 13 - 1872
8. AGE: Years 67 Months 3 Days 19 If less than one day ___ hrs. ___ min.
9. Birthplace Greencastle, Franklin Co. Pa.
(Town, county, and state)
10. Usual occupation Barber
11. Industry or business
FATHER 12. Name Jacob P. Shrader
13. Birthplace Greencastle, Pa.
MOTHER 14. Maiden name Ellen N. Lenhen
15. Birthplace Greencastle Pa.
16. Informant Miss Lillian Shrader
Address Hagerstown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof aug. 4-1939 (month) (day) (year)
Cemetery or crematory Greencastle
Location Greencastle, Pa.
18. Funeral director C. M. Suter & Sons
Address Hagerstown, Md
19. 8-3-1939 (Date rec'd by registrar) Chas H. Bowers Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 1 1939 at 8:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1939 to Aug 1 1939
and that I last saw h 1 alive on Aug 1 1939
Immediate cause of death Carcinoma of Face — DURATION 18 Mo.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. H. Beachley M. D. or other
Address Hagerstown, Md. Date signed Aug 2/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M) (T)

RECEIVED
AUG 14 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (131)

# CERTIFICATE OF DEATH

08292

Reg. Dist. No. 302

WITHIN CORPORATE LIMITS OF

**1. PLACE OF DEATH:**
County Washington
City or town County Home Hagerstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: none
Stay in ~~hospital or~~ inst. (yrs., or mos., or days) 1 week.
Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Wash.
City or town Smithsburg md Ward No. —
(If outside city or town limits, write RURAL NEAR and give town)
Street No. none
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR none

3. (a) FULL NAME Charlie A. Sigler

3. (b) Social Security Number

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife Catherine Sigler
6(c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.) 5-20-1876

8. AGE: Years 63 Months 2 Days 22 If less than one day — hrs. — min.

9. Birthplace Smithsburg md (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business none

FATHER
12. Name Michael Sigler
13. Birthplace Smithsburg md

MOTHER
14. Maiden name Margaret Ridenour
15. Birthplace Smithsburg md

16. Informant Gilbert Sigler
Address Cavetown md

17. (Burial, cremation, or removal. Which?) Date thereof Aug. 14, 1939 (month) (day) (year)
Cemetery or crematory Smithsburg 8. 14 1939
Location Smithsburg md

18. Funeral director Geo. R. Hoover
Address Smithsburg md

19. 8-12- 1939 (Date rec'd by registrar) Chas. H. Bowers, Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12 1939, at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 28 1939, to Mar. 31 1939, and that I last saw him alive on May 10 1939.

| Immediate cause of death | DURATION |
|---|---|
| Chr. myocarditis | 1936 |
| auricular fibrillation | 1938 |
| Chr. interstitial nephritis | 1937 |
| Acute dilatation heart | 8-12-39 |

Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy no

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide no Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE S. Roher & Wells deputy med. ex. Wash. Co. M. D. or
Address Hagerstown, md Date signed 8/12/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1939
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-C)

## CERTIFICATE OF DEATH

08293

Reg. Dist. No. 305

1. PLACE OF DEATH:
County Washington
City or town Mt. Etna (Beaver Creek)
(If outside city of town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Hagerstown Md. R.1
Stay in hospital or inst. (yrs., or mos., or days) at Home
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Mt Etna Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Hagerstown Md. R. 1.
(If rural give LOCATION)
2(a) ~~If veteran, name war~~

3. (a) FULL NAME: Mary Ann Sprecher

3. (b) Social Security Number

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife William S. Sprecher

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) September -5- 1856

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 10 | 26 | ____ hrs. ____ min. |

9. Birthplace Dilghmanstown Wash. Co. Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business own Home
FATHER 12. Name Solomon Smith
FATHER 13. Birthplace Dilghmanstown Wash. Co. Md.
MOTHER 14. Maiden name Elizabeth Moats
MOTHER 15. Birthplace Dilghmanstown Wash. Co. Md.
16. Informant Charles W. Sprecher
Address Hagerstown Md. R.1
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 3. 1939 (month) (day) (year)
Cemetery or crematory Mauer Cemetary
Location Near Dilghmanstown Wash. Co. Md.
18. Funeral director Wm. D. Bast & Son
Address Boonsboro Md.
19. Aug 2 1939 (Date rec'd by registrar) William D Bast Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August -1- 1939, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 17 1937, to Aug 1 1937 and that I last saw h alive on Aug 1 1937

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Embolism | 1 hour |
| Due to Arterio Sclerosis | 6 yrs |
| Due to Myocarditis | 4 yrs |
| Other condition — | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE B. G. Hokker M. D. or other
Address Smithsburg Date signed 8/1/39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
SEP 6 1939
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (20)

## CERTIFICATE OF DEATH

08294

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution: 47 Robert St
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 25 yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown Ward No. 5
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 47 Robert St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Emma Louise Stewart

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col. | Single |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28- 1905.

8. AGE: Years 34 | Months 1 | Days 0 | If less than one day hrs. min.

9. Birthplace Harrisonburg Va (Town, county, and state)

10. Usual occupation House work

11. Industry or business at Home

FATHER 12. Name William J. Stewart
FATHER 13. Birthplace Virginia

MOTHER 14. Maiden name Estella Watson
MOTHER 15. Birthplace Virginia

16. Informant Estella Stewart
Address 47 Robert St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof aug 26-1939 (month) (day) (year)
Cemetery or crematory Rosehill Cemetery
Location Hagerstown Md

18. Funeral director John M. Caldwell
Address 160 N. Jonathan Hagerstown Md

19. 8-25-1939 (Date rec'd by registrar) Elliott Bowers Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 8/23 1939 at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug-1 1939 to 8/23 1939
and that I last saw h[illegible] alive on 8/23 1939

| Immediate cause of death | DURATION |
|---|---|
| Entero-Colitis | 4-5 weeks |
| Peritonitis | " " " |
| Due to (2) | |
| Due to (3) | |
| Other conditions ✓ | |

(Include pregnancy within 3 months of death)

Major findings:
01 operations ✓
01 autopsy ✓

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ✓ Date of ✓
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ✓
Means of injury — Injured at work? ✓

23. SIGNATURE Victor D. Miller M. D. or other
DR. VICTOR D. MILLER,
Address 131 W. WASHINGTON, ST. Date signed 8/24/1939
HAGERSTOWN, MD.

RECEIVED
SEP 6 1939
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

08295

Reg. Dist. No. 316

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Washington

City or town Porterstown

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) 23 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md County Washington

City or town Porterstown Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. —

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

**3. (a) FULL NAME** Richard Filmore Stoner

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 3 - 1939

8. AGE: Years — Months — Days 23 If less than one day — hrs. — min.

9. Birthplace Porterstown - Wash - Md (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Richard Fred Stoner

FATHER 13. Birthplace Hagerstown

MOTHER 14. Maiden name Rosa A. Griffith

MOTHER 15. Birthplace Porterstown

16. Informant Richard Stoner

Address Keedysville

17. Burial — Date thereof Aug 27-1939 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Briar

Location Mt. Briar

18. Funeral director P. D. Saunders

Address Keedysville Md

19. Aug 26 1939 D. R. Keating (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1939, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 25 1939, to Aug 26 1939, and that I last saw him alive on Aug 25 1939.

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Atelectasis | One day |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE L. R. Stator M.D. (M. D. or other)

Address Keedysville Md. Date signed July 26, 1939

RECEIVED
SEP 6 1939
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08296

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

**1. PLACE OF DEATH:**

County Washington County

City or town Hagerstown Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Washington Co. Hospital

Stay in hospital or inst. (yrs., or mos., or days) 8 hrs.

Stay in this community (yrs., or mos., or days) Life

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Williamsport, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Conococheague St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Elizabeth Thomas

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Baby

8 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) ~~Oct~~ August ~~10~~ 9 1939

8. AGE: Years | Months | Days | If less than one day 13 hrs. ____ min.

9. Birthplace Williamsport Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Mike Thomas
13. Birthplace Hagerstown, Md

MOTHER
14. Maiden name Kathleen Spigler
15. Birthplace Williamsport Md

16. Informant Mike Thomas
Address Williamsport, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof ~~Aug~~ August 10 1939
(month) (day) (year)

Cemetery or crematory Riverview Cemetery
Location Williamsport, Md.

18. Funeral director Edith V Leaf
Address Williamsport, Md.

19. 8/10/ 1939 Chas H Bowers
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1939, at 1 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 9 1939, to August 10 1939, and that I last saw her alive on August 10 1939.

Immediate cause of death Prematurity 5 Mo.

Due to Atelectasis

Due to Cerebral Hemorrhage

Other conditions None

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy Same as listed above

DURATION
12 hrs.
12 hrs.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE Ralph L. Young M. D. or other
Address Williamsport, Md. Date signed 8/10/39

Note received from Dr. Young giving the date of birth as Aug 9. 1939. 10/6/39

RECEIVED
SEP 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

(159)

08297

Reg. Dist. No. 302

**1. PLACE OF DEATH:**

County Washington.

City or town Hagerstown.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown. Ward No. 5
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 574 Pen Mar Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Male Child of John Wiles.

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 18, 1939.

8. AGE: Years | Months | Days | If less than one day hrs. 15 min.

9. Birthplace Hagerstown
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name John Wiles.
13. Birthplace Mt Lena, Washington County.

MOTHER
14. Maiden name Mildred Wolf.
15. Birthplace Hagerstown, Md.

16. Informant Mrs Elmer Wolf.
Address Hagerstown,

17. (Burial, cremation, or removal. Which?) Date thereof 8/19/39 (month) (day) (year)

Cemetery or crematory Bellevue Cemetery

Location Hagerstown.

18. Funeral director Fred W. Kraiss.
Address Hagerstown, Md.

19. 8-19- 1939 Chas H Bowers
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18 1939, at 6:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/18 1939, to 8/18 1939, and that I last saw her alive on 8/18 1939.

Immediate cause of death Prematurity

Due to

Due to

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations None

Of autopsy None

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. F. Lusby MD
M. D. or other

Address 1 Dow Wayne Date signed 8/19/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1939
BUREAU V. S.